**Precision Medicine Podcast, Season 3, Episode 50**

**Dr. Kashyap Patel Tackles Oncology Treatment Disparities and Brings Light to the Darkest Areas of Cancer Care**

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**Karan Cushman, Producer:**  
Welcome to Season Three of the Precision Medicine Podcast sponsored by Trapelo. This is the podcast where experts come to discuss the problems oncologists, reference labs, and payers face as precision medicine grows and consider solutions for advancing the quality of patient-centered cancer care. Be sure to subscribe at precisionmedicinepodcast.com to get the latest episodes delivered straight to your inbox.

**Jerome Madison:**

Welcome to another episode of the Precision Medicine podcast. I'm Jerome Madison. And today we have Dr. Kashyap Patel, medical oncologist and CEO of Carolina Blood and Cancer Center. The current president of the Community Oncology Alliance or COA and author of a new book Between Life and Death: From Despair to Hope. Welcome to the podcast, Dr. Patel.

**Dr. Kashyap Patel:**

Thank you very much, Jerome. And thank you Karen for facilitating this conversation and allowing me to be part of the team today. And I would love to share my experience. So let's go right ahead, Jerome.

**Jerome Madison:**

Absolutely. So Dr. Patel, I have to tell you this, you've been on our wishlist since we started and we're about two years and 50 episodes in. And for our listeners, I only gave three current titles of what your roles are now, but you're a special kind of person because you have duties and roles as like medical directors to health plans and the leading voice in medical associations and you even train and coach physicians to be more effective in end-of-life situations that may come out in your book. We'll talk about that shortly, but to start, can you share with our audience what attracted you to the field of medical oncology and what gives you the drive to generously give your time and your talents to the international cancer community?

**Dr. Kashyap Patel:**

That's awesome question. And I'm going to reveal my age. I have to drive back 50 years in my life. So when I was nine years old, I went to watch a movie with my dad. That movie was one of the Hollywood movies called on Anand, A-N-A-N-D, and literal meaning is bliss. It was focused around a guy who gets lymphoma and then dies of it because there was no treatment options available at the time. He was a very popular and very famous hero. So I was kind of very sad. I liked that actor and so I kept crying for three days. I was barely nine years old and my dad, he was like a Saint. He said, "Boy, don't be sad. I mean, why don't you grow up and learn how to cure cancer?" And it stuck into my mind. And then, lo and behold, started my journey through high school and like anybody else, when I finished my high school. I was 23rd in the state so I had the option of going for space science. I think at the time the moon race was on. I'm going back to 1978.

And I almost forgot my promise to myself. And I was about to sign up to go to an engineering school, to study the space science. And I think that day, my dad handed me check for the fees, but he had kind of sadness in his eyes and said, "I thought you were going to become a doctor." And it reminded me, all the memories came back, and I tore that check. I applied to med school and got into med school of my choice in my hometown. So I continued my journey thereafter. And rest is a story. So I became an oncologist in India and then I went to England and had to do it all over again. I think the way every country's health care system is you have to train again. And I did my training again in UK. And then having been in England for four and a half years, I felt I could do more by coming to the US because this is the most progressive and most, I would say, dynamic society for the research.

So I came to US in 1996 and I had to go through it all again. And a lot of time my friends asked me, how could you do the same residency, the same chore, working hundred hours a week, three times in your life? And I stepped back and remind them that I don't make the same mistake again. So, that's my story of becoming an oncologist.

**Jerome Madison:**

I don't know about you but as a podcast listener, Dr. Patel, the things that are remarkable to me is I always gravitate to like the career path of the story. That is an incredible story of the seeds that are planted.

**Karan Cushman:**

I agree, Jerome. I have to say Dr. Patel, your career story became very personal as I was listening. I'm a lymphoma survivor and mine was a very advanced form. So I didn't have a lot of time to think about what I was going to do. Plus I was a new mom. So to hear that a movie about another lymphoma patient and your dad's advice is what inspired you to have a career, amazing career, should mention, as an oncologist, I think is just pretty awesome.

**Jerome Madison:**

Absolutely. Dr. Patel, one topic that you've been very upfront and passionate about is addressing healthcare disparities. And just a few months ago, I listened to a webinar that you participated in. I think it was for the American Journal of Managed Care.

**Dr. Kashyap Patel:**

Correct.

**Jerome Madison:**

Along with doctors Debra Pratt and the Karen Wingfield. You discussed a number of factors that contribute to disparities in health, in cancer care specifically. And what's clear from that conversation is there's disparities everywhere, all across the patient care continuum. So, I mean, when we talk about disparities, where do we start? How can we begin to think about the problem and see the bigger picture in order to make or even proposed effective changes that will benefit cancer patients in certain target populations?

**Dr. Kashyap Patel:**

That's a very interesting topic. And you exactly know where to kind of get my interest attracted. So, I actually started hearing more over disparity with COVID-19. I mean, we knew disparities existed before but it's COVID-19 that brought to light the extent to which the population can be impacted by multiple factors. And then I think cancer health disparity came to light when the American Association of Cancer Research did a lot of their work to try and find out the extent of disparities. So the question is what are we dealing with? About one in three cancer deaths can be prevented if we didn't have disparities. What's the financial impact? Almost $230 billion of excess spending between 2003 and 2006. And what's the indirect expense? Close to a trillion dollars in three years. So, when we ask what is it that we are dealing with? And when I share these numbers, Jerome, with anybody... I shared it with my Congressman, my local state senators, with my local state representatives. They all are in a state of shock. And it's because I don't think it was indeliberate.

I think it's all came to light because we learned about diversity in each human being. I'm different than you, you're different than Karen. Karen may be different than a Pacific Islander. So because there's so much biological diversity, but that alone is not enough to explain disparities. So in last six months, what I've done is I've read over 200 papers, cover to cover. Plus one of the book from a National Academy of Medical Sciences, the IOM, called Shorter Lives, Poorer Health. And then that sums up multiple public health issues that we deal with. So in last two weeks, I prepared what I call the cancer health disparity grid. And I'll send it to later on once we're done with conversation. So I started with the social determinants of health. Place where you were born, family that you grew up with, cultural beliefs that you have, economic status that you grow up, literacy that you have, biological diversity that you have, zip code that you live in, travel distance to your healthcare provider. Some of these are changeable. Some of these are not.

So I think that social determinants of health is probably number one that actually impacts some of the parts. And the next one came to my light was the preventive screening. I was not aware, Jerome, that up to 80% of the patients who are eligible for lung cancer screening based on the USP TF criteria, get screened for it. And this all is shocking. But actually, it came literally flying on my face and then I read more about it. And that's true. I think people who have 20 plus history of smoking, who qualify for screening still don't get it. So, and then these are insured person. It's not that they're uninsured. It's not about economy. It's about just ignorance. So the second grid I prepared was that of the access to screening. The third grid was actually access to testing and then testing includes mammography, cervical cancer screening, lung cancer screening, colorectal, but also the precision medicine. Access to biomarker testing.

We all know that lung cancer testing rate is half as much in the minority population as compared to majority population. We don't have genetic information on the ethnic minorities because the places where all the studies are created, these institutions located in the big cities, they attract more ethnocentric population, particularly in European continent. So, multiple factors contribute to the disparities and then going on to further access to care now, so your insurance, your out-of-pocket costs, your travel distance to the place where you go, all of these actually add to disparity. And the last one is access to clinical trials. So in my grid, I've actually kind of classified them based on hierarchical characteristics. And I plan to start by writing a blog on that probably within two weeks or so, so that we create almost like a movement of what we are dealing with. And then I'll pause and take any for the questions here.

**Jerome Madison:**

Well, you said a lot. So let's back up and kind of double-click as my good friend, Aubrey Kelly says, on a couple of things. You mentioned with COVID right, and how the disparities were exacerbated and became more apparent. And COVID is a good example that change in the healthcare system is not impossible when it needs to happen. So, the rapid access to testing and those types of things that were good innovations created, in some cases, unintended consequences of disparities. So, telemedicine became a great thing to stay in contact and keep care providers in touch with patients, but there exposed a disparity in those of the digital divide per se. One thing that you mentioned is the disparity in kind of the reference genome. So I think even the Community Oncology Alliance has issued a position statement on disparities in healthcare. And I heard you mentioned specifically that precision medicine treatment could present challenges for diverse populations that are not equitably represented in clinical research. Tell us a little more about that.

**Dr. Kashyap Patel:**

So, that's very interesting challenge that we all are going to face over the next 20 years. The genome-wide association studies, which is the global group that tracks the human genome analysis. You can do it by CGP, competence genomic profiling, whole exome sequencing, whole genome sequencing. And most of these are federally-funded program and they track the ethnicity of the human genome analysis per population. And what they were kind of shocked with in 2009, I remember, it could be a year here and there, is that 90% plus representation in the human genome analysis, were of the European ancestry. Now we are looking at the global population. So Europeans make about 9.7% of the global population. And in 2009, in spite of European population... Although European ancestry making less than 10% of the publishing bucket, there was nine times more representation on the genome studies. This came as a kind of rude awakening.

So most of the countries try to improve that number. But even as just recently as far as 2018, it still shows that 80% plus samples that are analyzed in the genomic studies still are that of the northern European ancestry and only 2% of the African-American, maybe of Africans. Not just the Africans, black population. Maybe 10% Asians and so on and so forth. The implications are the new drugs that are going to be developed based on precision medicine is going to be linked to the accessed information. So if the access to information is restricted to just one ethnic proportion, how can we expect some sort of fairness that our drugs will work equally well in every population?

And then I'm sure you know about the case in Hawaii where the Supreme court... Hawaii state actually has fined two large pharma companies $417 million each because they claim that couple of drugs that are used in patients after the heart attack has a very small chance of working in Pacific islands compared to mainstream, northern European population. According to them, their judgment, the chance of that drug working is one Pacific Islander to seven northern European ancestry population. So, we come to know that the biological diversity in the genome can dictate the outcome to a certain extent. And this is what worries me most that in 10 years from now, we may have a specific drug for a certain population, but we may be lagging behind by appropriate intervention for other populations.

**Jerome Madison:**

The precision medicine podcast will continue right after this

**Karan Cushman:**

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**Jerome Madison:**

In some of the things that you mentioned, you mentioned access, right, and access can stretch across multiple functions of the care continuum. Just in this conversation, you mentioned access to screening, access to testing, access to clinical trials. Dr. Karen Wingfield was the lead author on a paper published in JCO oncology practice, whose focus was to develop an actionable framework to address cancer care disparities in the US. And that can be found on ASCOpubs.org, for those who are interested. And you posted it on LinkedIn, obviously Dr. Patel has a great LinkedIn follow. This working group, it decided the framework should focus on more prevalent malignancies and of men and women and targeted those specific areas: screening, diagnosis, treatment, and survivorship. You mentioned a slightly different list, but the undertone of all of those is an emphasis on addressing barriers to access within these different domains. You made the comment earlier that 34% of all cancer deaths could be prevented if they did not have disparities in access to cancer care. What are some thoughts around how we can increase access across the care continuum?

**Dr. Kashyap Patel:**

That's, Jerome, very, very interesting topic. And I don't think we could take one size fits all approach. And the more I dive deeper into the disparity space, the more I study, the more I study on the political current, the more I realize that solution will not come from the new the legislation or even new mandate. I think the solution will come from local pilots. So what we see is what we can address it. For example, if an uninsured patient comes to my clinic, I'm able to find the foundation. I'm able to find economic help. I'm able to find free drugs for that patient. I'm able to write off the treatment cost for the patient. What we don't know is what we don't know what the extent of the other side is, is people who are not able to access the treatment. And I think it's simply because they are not able to get screened. They don't even know that there's a system exists to create the ecosystem to help them.

What we are going to do, and then I hope and pray their stakeholders stand up to support me, is to create a pilot called NOLA, No One Left Alone, in the congressional district five of South Carolina. And the idea is to create an ecosystem from the time that you find patients where they are. So I just was on call with Alliance imaging team, and I'm asking them, would you be able to prepare a mobile lung cancer screening program by using the low dose CT scan? It's because, for me, you and Karen on this conversation, it's easy to think yeah, I'll go 20 times to doctor's office. But for someone who barely makes $900 a month, who probably has a broken truck, who may have to travel 45 miles one way, if they have to go to doctor's office for 10 different screening beginning from pneumonia shot, Shingles shot to cervical cancer screening, to mammography, to lung cancer, they may end up in spending about $800 in transportation, back and forth to doctor's offices in a year's time. That's equivalent of their monthly income.

And then, so we never put that value of that intervention to that human being. So we are looking into creating... I mean, I hate to use this word Caravan, but I was talking to, again, my dear friend who works for Alliance imaging, Tina, and I said, "Can we just have a program that once every three months you select a place, more like a faith or worship place that you in the parking lot, you take portable mammography machine, you take portable phlebotomy where you could just draw the blood and you take portable CT scan machine. And you designate once every three months that you'll be rotating to that place." That may be the way that we can reach out to people who do not come out and understand the importance... Health literacy, social determinants of health. So patients or the citizens are willing to participate in the care, but they do not have resources to access what we're able to offer. So unless we break the silos of the compartments that exist within the healthcare delivery system, we cannot solve it.

It reminds me of Mahatma Gandhi's famous quote that "When you want to bring in the change, when you want to do something, remember the face of the poor of the poorest and the weakest of the weak. And if that intervention makes a difference in them, do it. If not, it may not be helpful."

**Jerome Madison:**

Incredible.

**Karan Cushman:**

So powerful.

**Jerome Madison:**

That is so powerful. NOLA. Something to remember.

**Dr. Kashyap Patel:**

I was going to send you. I think I'll send you the grid as well as what we plan to contemplate to do that. I've actually started working with state Medicaid agency, local city mayor, my Congressman. I think we ought to bring everyone together. And if I can touch 40 lives in one year in our congressional district, 40 times 400 congressional districts, about 16,000 lives could be touched by this sort of pilots.

**Jerome Madison:**

Well, I'm pretty confident that we've got some allies that can contribute to this effort. I think we'll get our good friend Michelle Buzhardt here involved. And I think we may have some people who might want to contribute to this because I hear a lot of conversations around disparities, but not many experts speaking at it at the level in which you are.

**Dr. Kashyap Patel:**

I'm actually an operations guy. So, I hope that we can get to see to the face-to-face, Jerome, but once you meet, I think you'll realize that if I create a problem, I also plan to bring the solution. I'm not somebody who wants that intellectual visibility by talking smart things. I really want to bring in solution. And you're right. I think there's so much help pouring out. I mean, there are who are willing to open up the doors and hearts. In fact, Michelle I've talked to her and she said, she wants to look at exploring that as well. So I do think I'll be able to find support that's good enough. I plan to start it sometime in September, October, a formal kind of kick-off ceremony.

**Jerome Madison:**

Well consider us allies and hopefully we do some good and come back on the podcast to talk about it.

**Dr. Kashyap Patel:**

Absolutely.

**Jerome Madison:**

Now I mentioned earlier, your book. Dr. Patel, you've got an enormous heart for your patients and also other care providers. In fact, you are a certified trainer for physicians with the education in palliative and end of life care. He's also a trainer who teaches other doctors how to initiate discussions around death and dying. Your new book is titled Between Life and Death: From Despair to Hope. Tell us what inspired you to write the book and the message that you would want readers to take away from that?

**Dr. Kashyap Patel:**

You're touching my heart here, Jerome, because like I said, I've lived in three different continents. 11 different cities. And the only thing I can say is that I was never prepared to understand how to talk to someone about their departure from this planet. It was hard and struggle for me, at personal level. No medical school education formally prepares you on like three or four lectures. Residency does not prepare you and everything is becomes a transactional. But when I started building up my own practice, when I saw that patients, they were getting ready to die, but I had difficulty telling them, "Well, I may not see you again." And I started kind of jotting down my notes. It was more like on-the-job training. And I started going to my patients' homes once I put them in hospice care to make sure that I continued that bridge.

And to a certain extent, I used to tell them that call me if you think that he or she is passing away, I'll be happy to be there. And I personally witnessed several patients leaving this word in my own presence. And lo and behold, came along this patient who was a British citizen, but he moved to US. He was one of the Air Force pilots. And his wife was the director of the cancer center at our hospital. And he had a stage four lung cancer, but having grown up in England, he knew more about hospice than anybody else in our area. And his first question was that, "Dr. Patel, how long do I have to live? So in my usual style," I said, "Well about two to three months, if you don't do anything and up to a year, if you do something." He said, "Can you guarantee that?" I said, "No, neither of them can be guaranteed." I said, "I don't know if I'll be around tomorrow or not. So I can get into about your life."

So after two or three meetings, he said, "You know what doc, I've decided I don't want to do anything whatsoever. But the only request I have is would you share your experience of how you have seen other patients dying? What happens when they die? What happens to the loved ones when the patient dies and how do they cope with that? And what happens to the body after that?" It was a challenge for me, but I said okay, let's start having a conversation. So we decided that every Wednesday which used to be my half day, I would sit under a healing dome. We have a beautiful copper dome at my office which is an outdoor structure. And we would sit there and we start talking about different cases. So I started discussing cases from as young as 26 year old girl to somebody who's 90 years old. And after about seven sessions, I could see that he was getting comfortable about his own death.

So then he said, "Well, doc, I think I'm ready for it. And thank you for doing this for me." And I want to add a couple of more kind of scenario there, because before we kind of pretty much said goodbye he said, "My only fear in this world is..." He was more like an agnostic. He didn't go to church when he was more agnostic and his only prayer is that I don't want my wife and my daughter to see me dying. And he said, my another daughter was fly from Australia may not be able to see me. I hope I can get some way to kind of put a closure to her. And then he went home. He was in a hospice care. And his wife called me one evening saying that "Kashyap, I think this may be last night for him." So I went to see him and kind of, he was almost comatose. I touched his hand, I kind of gently whispered in his ear and I told his wife and daughter as well, "That would you please give him permission to leave because I think he's wanting that permission."

So they both whispered in his ear as well. And I left, I came home. The next morning, his wife called and said, "Harry is not there anymore." And I said, "What happened?" She said, "Very interesting thing happened." It was, I think probably spring time and the windows were open and she said, "We have two stray cats that we've kind of adducted. And all of a sudden around one in the morning, they just jumped out of the bed and ran out." So my friend and her daughter, they both opened the door and ran out to see what happened, what was happening to the cats. And that's when Harry passed away. So even though Harry was not in control somehow he was able to dictate when he took his last breath, for the lack of better words. And coincidentally, his daughter was actually on the flight from Australia to the US, she landed next morning. She came home and asked his wife, I mean, her mom, that "Was this time that dad passed away?" She said, "Yeah, how do you know?" She said, " Just I felt something."

So these are the things that we can't explain with science, but these are some real life experience that people have experienced. And combining that with studying the different faith concept of death. For me to explain to Harry about what happens to body after death, I had to go back and learn in my own way from multiple different denominational literature about how Judaism perceives death, how Islam perceives death, how Christianity perceives death, how we kind of pretty much what we call industrialized death as a process during the civil war time, how the whole idea about embalming came existence, keeping body came into existence. It was a learning for me, but I've shared it as much as I can within the confines of the book.

**Jerome Madison:**

And I'm sure there are a number of incredible stories about your patient's experience with patients and families. It's not lost on me that as a cancer care provider, you're not immune to this stuff. I mean, we're human beings at the end of the day. From this perspective of mentoring and hearing from your peers, how do you suggest they manage the everyday stresses of just a medical practice, but the fact that some patients do die?

**Dr. Kashyap Patel:**

Jerome and Karen, every day I walk against my own horizon of death. I don't get dissuaded because the only thing I know for sure that will happen to all of us who exist in the manifest physical form is that the physical form will perish. Depending on your faith, whether you believe in reincarnation, whether you believe in going back to the Holy Father, would you believe in going back to different [inaudible 00:32:15]. It all depends on the conditioning and culture as well as phase. But the only thing I can say for sure is that I'm racing towards that horizon that's going to come one day. Instead of being dissuaded by not doing other things that fun I feel that live the life to the fullest and be ready for the worst to come any day. So accepting death with grace and blessing allows us to live to the fullest and knowing that it's something that's inevitable for all of us. If I do not know where I came from, where I was before I was born, why do I worry about where am I going after I'm dead?

**Jerome Madison:**

Wow, incredible, incredible, incredible conversation. Dr. Kashyap Patel, Until CEO of Carolina Blood and Cancer Center, current president of the Community Oncology Alliance. Speaking of the book and your social media, is there a website or a place where they can go pick up a copy of the book and follow you on social media?

**Dr. Kashyap Patel:**

Yeah. So the book is available on the Amazon as well as there's a website, www.betweenlifeanddeath.org. And that's a website and all of my social media accounts are tied to that. I also have a Twitter account and LinkedIn account in my name, Kashyap Patel Oncologist. So then Between Life and Death also has its own social media account as well. So look out for the updates on the book, what's coming next. I have two more book contracts. I'll kind of talk to you next time when we talk about it.

**Jerome Madison:**

Absolutely. Can't wait to do that. Well, before we let you go, we were talking kind of in our green room experience, Karen and I call it now. For someone who is as busy as Dr. Kashyap Patel, who travels internationally, who heads and leads a practice, and also a large community oncology association. We always like to dig into what your hobbies are, but this is not your first book. You actually are a bit of a photo journalist and have published a coffee table book of photos in nature, national parks. Tell us about that.

**Dr. Kashyap Patel:**

Yeah. So I've done everything possible that I can within this one lifetime. I can sell almost like eight lives. I got my ninth life going on right now. So when I was in my med school, finishing my med school, I had a crazy idea of traveling across India on a motorcycle. And I bought a camera, I slung it across my back, and I was popular enough to attract three other friends. So four of us started telling on the motorcycles back in India in 1984. And we traveled around like two months, different parts of the country, different parts of the state. And our rule was that we would not be spending money to staying in the motel. So we would knock somebody's door. In those days people trusted strangers. We would say we are for medical students, just finished med school. We are in between residency and med school. Do you mind if we stay with you? So I traveled in a tribal belt, through different terrains and compiled all the photographs. And then I came back and started my residency.

And in my third year of residency, I was free in the evening and I was getting bored. So I applied to local media, the Indian experts group of newspapers and said "Do you mind if I work here in any capacity?" So, it was a very big newspaper group and all the owner was very kind of smart. So he interviews me. He said, "There's a small cholera epidemic that has broken out in this slum. Would you want to do some report on that?" I went there, next day did report, put it on his desk. And he said, "Can you start working today?" So I started working as a photo journalist in that group, and over the years I've collected over like 5,000 different, beautiful pictures. And I saw that I needed to share my journey as a human being, apart from it as a doctor. So I complied some of the best pictures that I took across the world, beginning from the national parks to the wildlife in Africa. And then I said, either I can have a structured flow or just kind of random flow.

And I thought, let me kind of almost create an analogy to the life and death. So I said, let me create a title of the book called the Element to Life: Journey to the Self. So in the first 50 or so pictures, I have the photographs of the national parks monument, beginning from the earth, the water, the fire, the space, the birds, and then we move into the animals and then hierarchy leading to human beings. And with each photo I chose my wife and my son and his wife chose beautiful quotes. And this is self-published book. It's got its own ISBN number, but it's interesting journey. And I'll send you both a copy of that book, and then I'm sure you probably would love that as well.

**Jerome Madison:**

I would. It would definitely be on our coffee table. My wife, Kimberly is a huge fan of national parks.

**Dr. Kashyap Patel:**

Awesome.

**Karan Cushman:**

Same here. Thank you, Dr. Patel. I really look forward to getting the book and already feel compelled to get my own national park images out of storage and dust them off, so to speak. And to close us out on what is the 50th episode of the Precision Medicine podcast on behalf of myself, Karen Cushman, producer, our host, Jerome Madison, all of our listeners and our sponsor, Trapelo. Thank you, Dr. Kashyap Patel for being an amazing guest on the Precision Medicine podcast today, and for the winding journey you just took us all on. What it means to live life full and with purpose and what that looks like in the end. I think in this 40 plus minutes or so you slowed time for all of us, which in today's world, is a real gift. So thank you very much.

**Dr. Kashyap Patel:**

Thank you very much both Karan and Jerome, and I look forward to seeing you in person sometime soon.

**Karan Cushman, Producer:**

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**About Our Guest**

###### **Kashyap Patel, MD**

**Founder and CEO of Carolina Blood and Cancer Care Associates**

**President for the Community Oncology Alliance**

**Medical Director for the Blue Cross Blueshields of the SC Board Member of the Centene Corporation (SC) Medical Director of the International Oncology Network**

Kashyap Patel, is the founder and CEO of Carolina Blood and Cancer Care Associates. Dr. Patel is a full time practicing medical oncologist, board certified in Hematology, Oncology, and Internal Medicine and president of the Community Oncology Alliance (COA).

Dr. Patel also volunteers with many other leading national cancer and quality organizations. He is a consultant Medical Director for the Blue Cross Blue Shield of South Carolina (BCBSS); a CAC member for DHHS (SC) and Palmetto GBA; Medical Director of the International Oncology Network. Dr. Patel is past president of the South Carolina Oncology Society and has served as chairman of several committees in numerous South Carolina hospitals. He is chairman of the Biosimilars committee for the Association of Community Cancer Centers (ACCC). He is also a member of the CPC committee for the ASCO. He has testified before the South Carolina State Senate and briefed countless members of the United States Congress and their staff on critical community oncology issues.

With extensive expertise in value-based care, Dr. Patel has successfully led multiple oncology payment pilots in his practice and consulted on others across the state and nation. He has published or presented more than 70 original articles and abstracts in journals and/or meetings (nationally and internationally). Through this work, Dr. Patel received research merit awards for cancer research, including ASCO merit awards during his fellowship.

Dr. Patel has a special interest in health care policy, with a focus on racial and ethnic disparities and end of life care. An accomplished author, he recently published “Between Life and Death: From Despair to Hope,” a firsthand chronicle of real patients who have faced the end of life with understanding and acceptance. Dr. Patel is also associate editor in chief of Evidence-Based Oncology, a publication of the American Journal of Managed Care. Dr. Patel is quoted by local and national media including NY Times and has appeared on CBS Morning News.

Dr. Patel also has extensive experience in revenue cycle management (RCM) in oncology, including co-founding a large RCM company that has grown from four employees to more than 1,000 employees today. He recently started a research enterprise, the Community Clinical Oncology Research Network (CCORN), to support the recruitment and increased participation of independent oncology practices in cancer clinical research.

He has had extensive research experience in the field of oncology and has published and presented over 70 articles/abstracts in journals, nationally and internationally.